U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 28 April 2004

CASE NO. 2001-BLA-865

In the Matter of

JAMES O. GIVEN,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Larry Rowe, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by James O. Given, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, et seq. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to clams filed on or after January 19, 2001, *not* to pending cases.

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on November 19, 2003 in Charleston, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder. Furthermore, the record was held open for the submission of the post-hearing evidence, which have been marked and received as Employer's Exhibits 23, 24, and 25 (EX 23, 24, 25), and closing arguments (TR 56). The record consists of the hearing transcript, Director's Exhibit 1 through 39 (DX 1-39), Claimant's Exhibits 1, 2 and 4 through 10 (CX 1, 2, 4-10); and Employer's Exhibits 1 through 25 (EX 1-25). In addition, I have reviewed the parties' pre-hearing reports and their post-hearing briefs.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

Claimant, James O. Given, filed his initial application for black lung benefits under the Act on January 6, 1986 (DX 35-1), which was denied by the District Director's office on August 21, 1986 (DX 35-14). Claimant did not appeal nor take any action within one year of the above-referred denial. Accordingly, the 1986 claim has been finally denied and administratively closed (DX 39).

Claimant filed his second application for Federal black lung benefits on October 22, 1987 (DX 36-1). Following a formal hearing held on June 4, 1991 (DX 36-45), Administrative Law Judge Gerald M. Tierney issued a Decision and Order-Rejection of Claim, dated October 31, 1991 (DX 36-46). On appeal, the Benefits Review Board issued a Decision and Order, dated June 10, 1993, affirming Judge Tierney's denial of benefits (DX 36-55). Since Claimant did not appeal nor take any action within one year of the Benefit Review Board's denial, the 1987 claim has also been finally denied and administratively closed (DX 39).

Among the provisions which does not apply retroactively is 20 C.F.R. §725.309. *See* 20 C.F.R. §725.2. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao,* dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit Court issued its decision in *National Mining Ass'n, et al v. Dep't of Labor*, _____ F.3d _____ (D.C. Cir. June 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. Under the procedural history and facts herein, the Amendments do not affect the outcome of this claim.

On February 5, 1998, Claimant filed his third application for benefits under the Act (DX 37-1), which was denied by the District Director's office on July 28, 1998 (DX 37-25). Claimant did not appeal nor take any action within one year of the above-referred denial. Accordingly, the 1998 claim has also been finally denied and administratively closed (DX 39).

On October 12, 2000, Claimant filed the current application for black lung benefits under the Act (DX 1), which was granted by the District Director's office on April 23, 2001 (DX 30). Following Employer's timely controversion and request for a formal hearing (DX 31,33), this matter was referred to the Office of Administrative Law Judges for adjudication (DX 38). I was assigned the case on July 15, 2003. As previously stated, a hearing was held before the undersigned on November 19, 2003. The record was held open until January 16, 2004 for the submission of post-hearing evidence and briefs (TR 56).

Issues

Although Employer listed almost every relevant issue as contested on the Form CM-1025 transmittal sheet (DX 38), the primary contested issues are as follows:

I. Whether the miner has pneumoconiosis as defined in the Act and regulations?
II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?
V. Whether the evidence establishes a material change in conditions per 20 C.F.R. §725.309?

(TR 6-7).

Findings of Fact and Conclusions of Law

Background

A. Coal Miner and Length of Coal Mine Employment

On Claimant's initial application form, dated January 6, 1986, he alleged "38" years of coal mine employment ending on May 1, 1985, when he "retired" (DX 35-1). The October 22, 1987 application does not specify the number of years of coal mine employment, but it states that Claimant left the coal mines on April 30, 1985, when he "retired" (DX 36-1). On February 5, 1998, Claimant alleged 39 ½ years of coal mine employment ending on May 1, 1985, when he stopped working due to "health problems – retired." On the current application, Claimant alleged 39 years of coal mine work ending in May 1985, when "I retired because of breathing problems" (DX 1). Furthermore, at the formal hearing, Claimant testified that he engaged in coal mine employment for approximately 37 ¾ years; and, he served in the military for two years (TR 37-38). Employer concedes that Claimant worked as a coal miner for at least 17 years (TR 6).

Based upon my analysis of the evidence, including the documentary evidence, such as Employment History forms, Social Security records, and statements by co-workers, as well as Claimant's testimony, I find that Claimant has established approximately 37 ¾ years of coal mine employment ending in 1985. Furthermore, any discrepancy between my finding of "approximately 37 ¾ years" of coal mine employment and Claimant's prior statements the he worked as a coal miner for 38 to 39 ½ years, is inconsequential for the purpose of rendering this decision.

B. Timeliness of Filing

Claimant filed his current claim for benefits under the Act on October 12, 2000 (DX 1). Although Employer listed "timeliness" as a contested issue (DX 38), it failed to present adequate evidence to overcome the rebuttable presumption that the claim was timely filed. *See* 20 C.F.R. §725.309(c).[2]

C. Responsible Operator

Claimant 's last coal mine work was as an Assistant Maintenance Foreman for Employer, Consolidation Coal, the properly designated responsible operator, ending in 1985 (DX 1-6; TR 39,44,46).

D. Dependents

Claimant has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Naomi (nee Miller). (DX 1,9; TR 46).

E. Personal Background and Smoking History

Claimant, James O. Given, was born on July 1, 1928; he completed a 9th or 10th grade education. As stated above, Claimant engaged in coal mine employment for approximately 37 ¾ years; and, he retired on or about May 1, 1985. All of Claimant's coal mine work was spent underground, where he was exposed to considerable coal dust (DX 1; DX 35-1; DX 36-1; DX 37-1; TR 37-39,44). Claimant's last usual coal mine job was as an Assistant Maintenance Foreman. The job entailed a considerable amount of walking. Furthermore, Claimant also pitched in and helped the mechanics (TR 46-47). Accordingly, Claimant's work also entailed lifting, pushing, and other exertional work. However, as Claimant got older, the extent of his heavy, maintenance work was not nearly as much as before. Therefore, at the end, Claimant's primary duty entailed walking, which was still difficult for him to do, particularly when he had to carry anything (TR 51).

[2] Claimant testified that, in 1986, Dr. Rasmussen did not tell him he suffered from a totally disabling pulmonary problem. Furthermore, Claimant noted that Drs. Sembello and Bellotte had only told him he suffered from a totally disabling pulmonary condition about one year prior to the November 19, 2003 hearing. Finally, Claimant added a vague, inconclusive statement indicating that other physicians had previously told him he could not perform his job without specifying that he was totally disabled (TR 52-53).

Claimant testified that he suffers from breathing problems; and, that his condition has been worse over the past two years than it was when he quit mining (TR 44-45). He began taking oxygen a little more than a year prior to the hearing (TR 45). Claimant stated that he takes the oxygen each night and occasionally during the day, when he feels tired and weak (TR 40). Claimant also uses a nebulizer, Albuterol, for his breathing condition. He was first given breathing medication by a physician about five years ago; and, the medicine helped him "for awhile." (TR 49-50).

Claimant testified that he also suffered from various other health problems. He had two heart attacks in December 1993 and April 1994, respectively. Subsequently, in 1994, he underwent quadruple bypass surgery. In 1997 or 1998, he was diagnosed with congestive heart failure. Furthermore, in 2003, Claimant was hospitalized with pneumonia (TR 48-49). He takes pills for his heart, allergy, and high blood pressure (TR 46,48). Although Claimant has some arthritis, it does not preclude him from doing things; and, he does not take medication to treat it (TR 49).

Claimant acknowledged a cigarette smoking history of approximately ½ pack per day beginning at age 12, 13, or 14 (*i.e.,* 1940-42) and ending in 1986 (TR 40-42,48). Claimant testified that, after 1986, he smoked "maybe a half dozen" cigarettes during 1987. Thereafter, Claimant stated he tapered down and he has not smoked at all for several years (TR 44).

As summarized in Dr. Fino's report, dated September 18, 2001 (EX 4, p. 9), and further discussed below, the medical evidence contains conflicting cigarette smoking histories. However, I find that there is no reason for Claimant to have inflated his actual cigarette smoking history, since such action could undermine his black lung claim. On the other hand, understating his cigarette smoking history is self-serving. Notwithstanding Claimant's testimony, I find that the record contains credible medical evidence which establishes that Claimant has understated his actual cigarette smoking history. For example, in a report, dated June 9, 1986, Dr. Rasmussen stated that Claimant "has smoked ½ - ¾ pack of cigarettes daily for 50 years." (DX 35-12). More significantly, the Charleston Area Medical Center's History and Physical Examination report, dated December 13, 1993, states that Claimant has a "significant tobacco abuse history consisting of approximately one pack per day for 50+ years." The foregoing is listed under "Risk Factors" following Claimant's initial heart attack. Similarly, under "SH" (*i.e.,* Social History), the following notation is made: "Tobacco abuse, greater than 50 pack years. Denies alcohol abuse. Also occasionally chews tobacco. Reports that he has worked in the coal mines 40+ years and apparently has pneumoconiosis." Based upon the foregoing, I find that Claimant had an actual cigarette smoking history of approximately one pack per day for more than 50 years. Claimant acknowledges that he began smoking when he was 12, 13, or 14 years of age. I find that he continued smoking, at least, until the early 1990's. Moreover, as discussed below, the record contains additional medical reports which indicate that Claimant continued to smoke until the late 1990's. In view of the foregoing, I find that Claimant has a very significant cigarette smoking history which continued for many years after he left the coal mines.

Material Change in Conditions Under 20 C.F.R. §725.309

Under 20 C.F.R. §725.309(d), if an earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless there has been a material change in conditions or the later claim is a request for modification. Since the prior claims were finally denied (DX 39), and Claimant's current application for benefits was filed more than one year after the most recent final denial (DX 37-25; DX 1), the current claim is a duplicate or additional claim, not a modification request under §725.310. Accordingly, I must make a threshold determination as to whether the evidence submitted since the prior denial is sufficient to establish a material change in conditions pursuant to 20 C.F.R. §725.309(d).

As Claimant last engaged in coal mine employment in West Virginia (DX 2), this matters arises within the jurisdiction of the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP,* 12 BLR 1-200 (1989)(en banc). The standard for determining whether a material change has occurred in the United States Court of Appeal for the Fourth Circuit was set forth in *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd.*, 86 F. 3d 1358 (4th Cir. 1996)(en banc), *cert. denied,* 117 S. Ct. 763 (1997), which followed the one-element standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994). Under this standard, I must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. At that point, I would be required to make a *de novo* review of the entire record, including that evidence which was submitted with the previous claims, in order to determine whether Claimant is eligible for benefits.

The most recent prior claim, dated February 5, 1998, was denied on May 28, 1998 and July 28, 1998, based upon the District Director's findings that the evidence did not show that Claimant has pneumoconiosis; that the disease was caused by coal mine work; and/or, that Claimant is "totally disabled by the disease" (DX 37-18; DX 37-25). In the latter finding, the District Director merged the "total disability" and "causation" issues. However, the attachment to the May 28, 1998 denial letter included the results of pulmonary function and arterial blood gas studies, dated April 8, 1998. Although the pulmonary function results were not qualifying, the arterial blood gas test yielded qualifying values. Furthermore, the District Director stated:

> NOTE: Although the results of the breathing test and/or the blood gas test meet the disability standards described above, the evidence does NOT establish that your impairment was caused by black lung disease.

(DX 37-18). This indicates that the District Director's finding that Claimant had not established that he is "totally disabled by the disease" focuses on the "causation" issue, not the "total disability" issue.[3] Accordingly, the elements of entitlement which were adjudicated against Claimant in the final denial of the most recent claim were as follows: pneumoconiosis, causal

[3] In contrast, the Benefits Review Board's Decision and Order, dated June 10, 1993, which constitutes the final denial of the October 22, 1987 claim, affirmed the administrative law judge's finding that Claimant had not established total disability (DX 36-55).

relationship, and causation. Therefore, in order for Claimant to establish a material change in conditions under §725.309, Claimant must establish one of these elements of entitlement.

New Medical Evidence

The medical evidence includes various recent chest x-ray interpretations, pulmonary function studies, arterial blood gases, and physicians' opinions, which were obtained after July 28, 1998, the date upon which the most recent prior claim was finally denied (DX 37-25).

A. Chest X-rays

The record contains numerous x-ray interpretations of recent films dated December 13, 1998 (DX 37-28), November 14, 2000 (DX 15/16; DX 17,28; EX 1), March 22, 2001 (DX 34; EX 4,6), August 14, 2001 (EX 14), September 13, 2001 (EX 14), March 27, 2002 (EX 14), April 30, 2003 (CX 8; EX 16,17,19), and October 9, 2003, respectively (CX 2; EX 20).[4]

Of the twenty interpretations of the more recent films, four are positive for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, the readings by Drs. Gaziano (1/0) and Dr. Morgan (1/0) of the November 14, 2000 chest x-ray (EX 17; EX 1); Dr. Patel's (1/1) interpretation of the April 30, 2003 x-ray (CX 8), and, Dr. Gaziano's (1/2) finding on the October 9, 2003 film (CX 2).[5] All of the foregoing are B-readers. Furthermore, Dr. Patel is a dual-qualified B-reader and Board-certified radiologist.

On the other hand, the remaining interpretations of the above-listed films are negative (0/0 or 0/1) for pneumoconiosis under the classification requirements stated in §718.102(b). These include multiple interpretations by B-readers such as Drs. Renn (DX 37-28), Bellotte (DX 27,34), Hayes (DX 28), Fino (EX 4), Wheeler (EX 14,16,20), Scatarige (EX 19), and Scott (EX 19,20). Moreover, Drs. Hayes, Wheeler, Scatarige, and Scott are dual-qualified B-readers and Board-certified radiologists.

In summary, the clear majority of the interpretations are negative for pneumoconiosis, including those by B-readers and/or Board-certified radiologists who evaluated the recent films. Accordingly, I find that the preponderance of the x-ray evidence is negative for pneumoconiosis.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

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[4] The case file also contains interpretations of x-rays, which were submitted after the District Director's final denial of July 28, 1998, but which involved films dated prior to the denial date (DX 37-27; EX 1,3). The overwhelming preponderance of these submissions are negative for pneumoconiosis.

[5] Although Dr. Morgan reported a 1/0 reading on the November 14, 2000 x-ray, he did not attribute such abnormalities to coal worker's pneumoconiosis (EX 1,18). Nevertheless, for the purpose of weighing the x-ray evidence under §718.202(a)(1), I find that Dr. Morgan's 1/0 reading is positive for pneumoconiosis.

The record contains recent pulmonary function studies which were performed by Claimant on November 14, 2000 (DX 10,11), March 22, 2001 (DX 29,34), and April 30, 2003 (CX 3), respectively. The reported results were as follows:

Exhibit	Date	Ht./Age	FEV1	MVV	FVC	FEV1/FVC
DX 10	11/14/00	70"/72	1.84	83	3.50	53%
DX 29,34	3/22/01	68"/72	1.72	56	3.44	50%
DX 29,34	3/22/01	68"/72	2.16*	88*	3.87*	56%*
CX 3	4/30/03	67"/74	1.62	58	3.39	48%
CX 3	4/30/03	67"/74	1.69*	75*	3.65*	46%*

* = Results after bronchodilator

Under the regulatory criteria set forth in Part 718, Appendix B, the qualifying values diminish with age. However, since the regulations do not extend beyond age 71, the above-listed studies are all evaluated on the basis of a person who is 71 years old. Based upon the average of the above-listed heights, I find that Claimant is approximately 68.5" tall. On the basis of Claimant's age, sex, and height, the qualifying values on all of the above-listed pulmonary function studies are as follows: FEV1-1.76, FVC-2.28, MVV-70. *See* Part 718, Appendix B.

Pursuant to §718.204(b)(2)(i), the FEV1 value must be equal to or less than 1.76 *and either* the FVC *or* MVV must be at or below the above-stated values, *or* the FEV1/FVC ratio must be 55 percent or less. Accordingly, the November 14, 2000 pulmonary function test and the March 22, 2001 post-bronchodilator study are not qualifying. On the other hand, the March 22, 2001 pre-bronchodilator test is qualifying; and, the April 30, 2003 pulmonary function tests, which were conducted before and after bronchodilator, are both qualifying. Since the majority of the recent pulmonary function studies are qualifying, such evidence tends to support a finding of total disability.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes recent arterial blood gas studies which were administered on November 14, 2000 (resting only) (DX 14), March 22, 2001 (resting only)(DX 29,34), and, April 30, 2003 (resting and exercise)(CX 9). Of the foregoing, only the exercise study, dated April 30, 2003, yielded qualifying values under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. Thus, even though a clear majority of the arterial blood gas tests are not qualifying, the most recent exercise study is qualifying. Taken as a whole, I find that the arterial blood gas study evidence neither precludes nor establishes total disability.

D. Physicians' Opinions

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. §718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. §718.204(b)(2)(i), (ii), or (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. §718.204(b)(2)(iv).

The case file includes the recent medical reports and/or depositions of Drs. Scattaregia (DX 13,34), Bellotte (DX 34; EX 9,13,21,22), Morgan (EX 1,11,18,25), Fino (EX 4,12,21,24), Renn (EX 8,10), Rasmussen (CX 1,7), Sembello (CX 5), and Gaziano (CX 6).[6]

Dr. Frank A. Scattaregia, who is Board-eligible in Internal Medicine and has been involved in conducting black lung evaluations (DX 34, pp. 3-5) examined Claimant on November 14, 2000 (DX 13). Dr. Scattaregia completed a U.S. Department of Labor form, in which he reported that Claimant had a 40-year underground coal mine employment history. In addition, the form report includes Claimant's family, medical and social histories. Under "Social History," Dr. Scattaregia reported that Claimant smoked 1/2 pack of cigarettes daily for 30 years ending "14 yrs ago" (*i.e.,* 1986). (*Compare* DX 36-11).[7] In his summary of diagnostic test results, Dr. Scattaregia reported the following: Chest x-ray-"ILO Classification 0/0;" Vent Study (PFS)-"Moderate Obstructive Lung Disease;" Arterial blood gas-"PO2 80 PCO2 38 PH 7.42;" ECG-(Illegible) (DX 13, Sec. D5). Under the "Cardiopulmonary Diagnoses" section of the report, Dr. Scattaregia stated: "S/P CABG, COPD, No CWP" (DX 13, Sec. D6).[8] Dr. Scattaregia's other responses to the form questions regarding the etiology of the foregoing conditions, severity of impairment, extent to which each diagnosis contributed thereto, and non-cardiopulmonary diagnosis, are illegible (DX 13, Secs. 7,8,9).

Dr. Scattaregia testified at a deposition held on April 6, 2001 (DX 34). He sought to explain the apparent conflict between his diagnosis of simple pneumoconiosis in December 1987, and his subsequent finding of no pneumoconiosis in November 2000. In summary, Dr. Scattaregia stated that his 1987 finding of simple pneumoconiosis was based upon Dr. Harry

[6] Other medical evidence was filed by Employer after the final denial, dated July 28, 1998, of the most recent prior claim (DX 37-25), such as the medical treatment records from Charleston Area Medical Center, dated December 13, 1993 through May 1, 1994 (DX 37-27). The foregoing records confirm Claimant's history of heart problems and bypass surgery. Furthermore, as discussed above, they provide relevant information regarding Claimant's smoking history. However, such evidence does not address the issue of whether Claimant's condition has materially changed since the July 28, 1998 denial.

[7] When Dr. Scattaregia previously examined Claimant on December 15, 1987, Mr. Given was reportedly still smoking; and, Claimant had already smoked ½ pack per day for 50 years (DX 36-11).

[8] In contrast, on his December 15, 1987, Dr. Scattaregia diagnosed "simple pneumoconiosis" without providing any rationale for his finding. Furthermore, he did not address any other questions regarding etiology, impairment, etc. (DX 36-11).

Kennedy's x-ray interpretation (DX 34, p. 8). When told of a rereading by Dr. Gaziano, which was negative for pneumoconiosis and indicated abnormalities in the lower lung zones, Dr. Scattaregia opined that the x-ray is really not consistent with coal worker's pneumoconiosis. Moreover, Dr. Scattaregia stated that, even Claimant had pneumoconiosis in 1987, it was not causing a pulmonary impairment, as indicated by the arterial blood gases and pulmonary function results in 1987 (DX 34, pp. 8-10). Following a further discussion of the more recent examination and clinical test results, Dr. Scattaregia opined that, if Claimant were medically treated to his maximal improvement, he would only have a "mild" impairment. Furthermore, Dr. Scattaregia attributed the lung impairment primarily to cigarette smoking. Finally, Dr. Scattaregia stated that he would not diagnose coal worker's pneumoconiosis in this case. He does not believe that Claimant suffers from a chronic dust disease of the lungs arising from coal dust exposure (DX 34, pp. 10-17).

Dr. John A. Bellotte, a B-reader who is Board-certified in Internal Medicine and Pulmonary Medicine, examined Claimant on March 22, 2001 (DX 34). In his report on that date, Dr. Bellotte set forth Claimant's employment, smoking,[9] and medical histories, findings on physical examination, and clinical test results obtained on March 22, 2001. Moreover, Dr. Bellotte also provided a detailed summary of other available medical data. Based upon the foregoing, Dr. Bellotte stated:

> 1. There is insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis with respect to this man.
> 2. The claimant suffers from a mild pulmonary impairment which I would attribute to his chronic obstructive pulmonary disease with emphysema related to his history of tobacco abuse, which is quite a bit higher than previously listed in the records. In addition, this gentleman now suffers from asthma, which is a condition not associated with coal workers' pneumoconiosis but there is a genetic disposition for this diagnosed condition. This gentleman's mother did have asthma and he is now being treated for such and is steroid dependent.
> 3. He has old granulomatous lung disease on his chest xray (sic), which is of an old infectious etiology and not related to coal dust exposure.
>
> This gentleman is now totally and permanently disabled to such an extent that he would be unable to perform his last coal mining work or work requiring similar effort. That disability is related predominantly to his cardiac dysfunction but also to his mild chronic obstructive pulmonary disease with emphysema and asthma. This disease is not caused in whole or in part by coal workers' pneumoconiosis. This gentleman would be as disabled as he currently is if he had never set foot in a coal mine.

(DX 34).

[9] Dr. Bellotte reported that Claimant "started smoking at the age of 16 and he stopped his smoking habit in 1986. Therefore, he has had over a 50 year history. He told me that he smoked at the rate of a pack of cigarettes a day. That would be greater than 50 pack year smoking history." (DX 34). I note, however, that, if Claimant began smoking at age 16 and quit in 1986; then, he actually smoked for 42 years, since Claimant was born in 1928 (DX 1). However, as discussed above, I find that Claimant continued smoking for several years after 1986. Furthermore, Claimant testified that he actually began smoking when he was 12, 13, or 14 years old (TR 48).

Dr. Bellotte testified at deposition held on January 11, 2002 (EX 9). Following a further discussion of the medical evidence, Dr. Bellotte stated: Claimant does not have any chronic coal mine dust induced lung disease; Claimant does suffer from chronic obstructive pulmonary disease with chronic bronchitis and emphysema, as well as an asthmatic condition. Furthermore, Claimant has some scarring from previous pneumonia and he has a history of coronary artery bypass surgery. Moreover, Dr. Bellotte opined that, with appropriate asthmatic medications, Claimant retains the pulmonary capacity to perform his last coal mining job, noting that they would control his reversible obstructive impairment (EX 9, pp. 25-26).

Dr. Bellotte issued a supplemental report, dated August 14, 2002 (EX 13), in which he reviewed a letter by Dr. Sembello, where the latter physician opined that Claimant suffers from some work related chronic fibrotic lung disease. Dr. Bellotte disagreed with Dr. Sembello's conclusion, citing Claimant's records since he left the coal mines in 1985. In summary, Dr. Bellotte opined that the clinical test results, and the time and course of Claimant's pulmonary condition and treatment, are not those seen in coal workers' pneumoconiosis. Dr. Bellotte found that Claimant's impaired diffusion capacity are related to chronic obstructive pulmonary disease with emphysema and cardiac disease. Finally, Dr. Bellotte noted that the abnormalities shown on x-rays and pulmonary function tests are easily attributable to other diagnosed conditions (*i.e.,* non-coal mine related), which developed and progressed since Claimant retired from the coal mines (EX 13).

Dr. Bellotte issued another supplemental report, dated October 29, 2003, in which he reviewed and additional medical evidence (EX 21). In summary, Dr. Bellotte stated:

> I would refer you to my letter dated August 14, 2002, in which I have reviewed a large volume of information on Mr. Given dated from the time he left the mines in 1985 through the present day results. In reviewing all these records, we have the advantage of having a longitudinal history of the medical records of Mr. Given and can tell that when he left the coal mines he was in fairly good condition until he had his myocardial infarction in 1993. We are now reading chest x-rays on Mr. Given eighteen years after he left the coal mine which includes eighteen years of medical insults to his lungs. It becomes difficult, on just reading a chest x-ray after a patient has reached this age to decide what might actually make up a change related to coal dust exposure. However, based on my careful examination of all the records in file, I can say that there is insufficient objective evidence to justify a diagnosis of coal workers pneumoconiosis with respect to this man. He did have sufficient coal mine employment to cause a coal dust related disease but I did not find that abnormality on the chest x-ray nor do I suspect that abnormality from my history and physical examinations on this gentleman. We have adequate explanation to justify his mild pulmonary impairment which had developed since he left the coal mine. He subsequently developed even greater cardiopulmonary deficit and is totally and permanently disabled to the point where he would be unable to perform his last coal mining duties or work similar to that. There is no impairment which I would attribute to coal mine workers pneumoconiosis. He is no longer able to do his regular coal mining job, but not very many 75 year old men can do their previous coal

mining occupations especially after they have had myocardial infarctions and untreated asthma for years and a condition of COPD related to tobacco abuse.

I would not be surprised if coal dust macules were found if he were to ever have an open lung biopsy of this gentleman since he did have 38 years in the coal mines. However, it is my opinion that I can state with a reasonable degree of medical certainty that coal dust exposure would not be responsible for this gentleman's cardiopulmonary disability. I have examined many miners and non-miners in my pulmonary career. I have examined many patients with COPD with atheriosclerotic coronary artery disease who have not been coal miners and have suffered the same fate as Mr. Given.

It is my impression that Mr. Given would have the same disability if he had never stepped foot in a coal mine.

(EX 21).

Dr. Bellotte testified at a second deposition on November 3, 2003 (EX 22). Dr. Bellotte summarized his prior findings. In addition, prior to the deposition, Dr. Bellotte reviewed the records from St. Joseph Hospital, dated April 6, 2003 May 17, 2003, as well as Dr. Rasmussen's report, dated April 30, 2003 (EX 22, pp. 8-10). Dr. Bellotte stated that you cannot reliably assess Claimant's pulmonary capacity based upon Dr. Rasmussen's evaluation on April 30, 2003, because it was too soon after Claimant suffered a bout of acute pneumonia (EX 22, pp. 17-18). Following additional testimony, Dr. Bellotte reiterated that Claimant does not suffer coal worker's pneumoconiosis and Claimant's pulmonary problems are not related to his history of coal mine dust exposure. On the other hand, Dr. Bellotte acknowledged that Claimant suffers from pulmonary problems due to other causes, such as cigarette smoking and asthma; an, that he also has a significant history of heart disease. Taken as a whole, I find Dr. Bellotte's testimony was ambiguous regarding whether Claimant's [non-coal mine related] respiratory or pulmonary condition alone prevents him from performing his last usual coal mine job. However, Dr. Bellotte found that Claimant could not return to his former coal mine employment due to his "combined cardiopulmonary disability," which was unrelated to pneumoconiosis and/or coal mine dust exposure (*See,* EX 22, pp. 20-21,40-43,49-52).

In a supplemental report, dated December 16, 2003 (EX 23), Dr. Bellotte reviewed the deposition transcripts and recent reports of Drs Gaziano and Rasmussen, dated November 14, 2003 and November 18, 2003, respectively. In summary, Dr. Bellotte disagrees with Dr. Gaziano's diagnosis of coal workers' pneumoconiosis. Furthermore, Dr. Bellotte noted that Dr. Rasmussen had inaccurately represented that Claimant had stopped smoking in 1986. More significantly, Dr. Bellotte cited the clinical test results, his own analysis of the "longitudinal records," and his own experience as a physician in active practice of clinical pulmonary medicine. In summary, Dr. Bellotte concluded:

I have the opportunity to see on a daily basis, smokers and nonsmokers as well as miners and non-miners. In my daily practice, I see patients very similar to Mr. Given who are disabled and have never been exposed to coal mine dust. I have reviewed eighteen years of documented medical history after Mr. Given retired from the coal mines. I therefore

> have a significant advantage in coming to what I believe is the proper conclusion in this case. Mr. Given clearly has asthma which was not adequately treated for a significant amount of time which has lead to remodeling and caused an increase in his deterioration due to his COPD. This condition along with his cardiac condition has disabled Mr. Given and caused his x-ray abnormalities. Because of this, I can state with a reasonable degree of medical certainty that Mr. Given's disability is not related in whole or in part to coal mine induced dust disease.

(EX 23).

Dr. W.K.C. Morgan, a B-reader who is Board-certified in Internal Medicine and Pulmonary Diseases, reviewed the available medical evidence in a report, dated May 26, 2001 (EX 1). Based upon his analysis of such evidence, Dr. Morgan concluded:

> [T]here is no objective evidence available to justify a diagnosis of CWP. Mr. Given has a moderate respiratory impairment of an obstructive nature which is a result of his cigarette smoking. He is totally and permanently disabled to such an extent that he would be unable to do his regular coal mining work on account of firstly, his age, and secondly because of his heart disease and pulmonary impairment.

(EX 1).

In a report, dated June 2, 2001, Dr. Morgan interpreted various chest x-rays, which were conducted on February 24, 1986, December 15, 1987, April 8, 1998, and November 14, 2000. The 1986, 1987, and 1998 do not establish pneumoconiosis under the classification requirements set forth in §718.102(b). However, as stated above, the November 14, 2000 film was interpreted by Dr. Morgan as "1/0," which meets the classification requirement for pneumoconiosis. In summary, Dr. Morgan stated: "The changes in the lower zones are now enough to call 1/0, and there are also new linear opacities in the right and left mid zones. None of the changes suggest CWP. The appearances are those of emphysema with chronic obstructive pulmonary disease, along with scanty irregular opacities." (EX 1).

Dr. Morgan issued a supplemental report, dated July 4, 2002 (EX 11), in which he reviewed and analyzed a medical report by Dr. Sembello, who was Claimant's primary physician. Citing various x-ray interpretations and other clinical data, Dr. Morgan disagreed with Dr. Sembello's opinion that Claimant suffers from work related chronic fibrotic lung disease. In summary, Dr. Morgan stated:

> Mr. Given was a heavy smoker and has significant airways obstruction with an FEV1/FVC of 50%. His reduced lung function tests, including the DLCO, are caused by emphysema and not CWP. This is described in greater detail in the Summary of my report of May 26th, 2001. In short, my prior opinions still stand despite Dr. Sembello's proclamations and assertions.

(EX 11).

In another supplemental report, dated October 22, 2003 (EX 18), Dr. Morgan various additional data, including the following: his own July 4, 2002 report; Dr. Rasmussen's report dated April 30, 2003, in conjunction with an earlier report, dated June 9, 1986; Dr. Patel's chest x-ray reading of the April 30, 2003 film; and, the other clinical test results obtained by Dr. Rasmussen on that date. Based upon the foregoing, Dr. Morgan concluded:

> As far as I am concerned it is evident that Mr. Given has significant airways obstruction which I would rate as moderate. The spirometry, however, is not at all bad for somebody who is aged 74 years and who smoked at least ¾ of a pack of cigarettes a day for 50 years or more, along with an occasional cigar. In this connexion (sic), it needs to be pointed out that Mr. Given, when it came to his cigarette smoking history, tends to be extremely economical with the truth with the latter varying greatly. Moreover, his smoking is not limited to cigarette as is evident from the material that has been sent to me. Furthermore, he has cardiac disease and CABG which will also reduce his ventilatory capacity.
>
> In answer to your [Employer's representative] questions, there is insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis (CWP) based upon the available data. It is likely that Mr. Given may have mild CWP in view of the long time that he worked in coal mining. There is, however, no definite radiographic evidence of this condition or its effects. Even were Mr. Given to have simple CWP, it is in no way related to the development of his airways obstruction. In response to Question #2, I have made it clear that Mr. Given has mild respiratory impairment which is the result of prolonged smoking. You further asked me whether Mr. Given is totally and permanently disabled, etc., to the extent that he would be unable to do his regular coal mining work. At the age of 74 years, even if he had absolutely normal lungs, he would not be able to work in the mines, especially in view of the fact that he has airways obstruction and also has cardiac disease which is one of the larger factors that needs to be taken into account. I have already answered Question #4. Finally, my opinion would not change were Mr. Given found to have CWP. As such, it would be mild since there is no radiographic evidence of the latter condition.

(EX 18). In a post script, Dr. Morgan added the following: I received an x-ray reading from Dr. Gaziano of a film taken on 10/09/03. He [Dr. Gaziano] saw some q and t opacities in all zones and also thinks that Mr. Given may have tuberculosis. I do not believe he [Claimant] has significant pneumoconiosis nor do I believe there are any q opacities present in the film. The t opacities are a response to prolonged smoking." (EX 18).

In another supplemental report, dated December 14, 2003 (EX 25), Dr. Morgan reviewed the reports of Drs. Gaziano and Rasmussen, dated November 14, 2003 and November 18, 2003, respectively. Dr. Morgan provided a detailed discussion and analysis of the medical literature cited by Dr. Rasmussen, which Dr. Morgan found unpersuasive. In addition, Dr. Morgan criticized Dr. Gaziano's analysis of the medical evidence (EX 25).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 5), who had previously provided reviewing reports, dated December 28, 1990 and April 24, 1991, issued a report, dated September 18, 2001, in which he provided a

lengthy review and analysis of the available medical data (EX 4). Based upon the foregoing, Dr. Fino concluded:

> Taking into consideration the fact that he [Claimant] has only a minimal pulmonary impairment following bronchodilator therapy, it is my opinion that he does not have a respiratory disability. From a respiratory standpoint, he could return to his last mining job or a job requiring similar effort.
>
> It is still my opinion that this is a smoking related abnormality. This is especially consistent with the fact that he has had worsening in his ventilatory function during a time period when he was no longer exposed to coal mine dust, but he continued to smoke. Also, there was evidence of significant reversibility, which is inconsistent with a coal mine dust related pulmonary condition.
>
> It is my opinion, based upon the information reviewed, that this man would be as disabled as I find him now had he never stepped foot in the coal mines. He is disabled due to cardiac disease.
>
> From a respiratory standpoint, this man could return to his last mining job or a job requiring similar effort.

(EX 4).

In a supplemental report, dated July 15, 2002 (EX 12), Dr. Fino reviewed and analyzed Dr. Sembello's report, dated December 19, 2001, and concluded that he did not agree with it. In summary, Dr. Fino stated that the "objective data does not point to a fibrotic lung condition regardless of cause as contributing to this man's respiratory impairment. Coal mine dust inhalation did not produce a fibrotic lung disease in this man. It is still my opinion that coal mine dust inhalation was not a contributing factor to his lung disease and pulmonary impairment." (EX 12).

On October 28, 2003, Dr. Fino issued a supplemental report, in which he summarized his prior findings as follows: "It has always been my opinion that this man has a non-disabling pulmonary impairment which was unrelated to the inhalation of coal mine dust. Mr. Given has an impairment that is secondary to cigarette smoking, and a whole man disability due to cardiac disease." (EX 21). Following his analysis of additional medical data; namely, Dr. Rasmussen's report and clinical test results obtained on April 30, 2003, Dr. Fino stated, in pertinent part:

> Based on the FEV1 measured by Dr. Rasmussen on 6/9/86 compared to the most recent FEV1 measurement by Dr. Rasmussen on 4/30/03, there has been a 1400 ml drop in FEV1 over 17 years. The drop in the FEV1 is about 82 ml per year. This is an accelerated loss of FEV1, much greater than would be explained by either age or coal dust exposure.
>
> Although there is evidence in the medical literature that coal mine dust exposure causes obstruction, the obstruction due to chronic bronchitis or chronic obstructive pulmonary

disease is expected to be present at the time a coal miner leaves the mines. In the absence of the development of significant scarring or fibrosis, the development of new obstruction after a miner leaves the mines would be unusual in a coal dust-related lung condition. Although coal workers' pneumoconiosis may be progressive, the epidemiologic studies have shown that, on average, the loss of FEV1 in a miner after leaving the mines is somewhere around 11 milliliters of FEV1 per year. Over a period of 17 years, this would be about a 185 milliliter loss. This is far less than the 1400 milliliter loss that is seen in the FEV1 between 1986 and 2003. There has been no change in this man's chest films to indicate fibrosis or scarring.

Although I cannot exclude a clinically insignificant loss in FEV1 due to coal mine dust a described above, it is not the type of loss that has caused or contributed to this man's obstructive impairment. In fact, the obstructive impairment that is present now, as measured by Dr. Rasmussen, would prevent this patient from returning to his last job in the mines.

The accelerated decline in lung function over time is quite consistent with cigarette smoking. It has clearly been demonstrated in epidemiologic studies that, even if one would quit smoking, and 80 to 100 milliliter loss of FEV1 per year can be seen in ex-smokers.

The drop in pO2 with exercise noted by Dr. Rasmussen is also consistent with cigarette smoking.

(EX 21). In addition, Dr. Fino addressed the x-ray findings of Dr. Gaziano, in conjunction with other interpretations, and stated that "the changes noted by Dr. Gaziano cannot be related to coal dust exposure."

In summary, Dr. Fino reiterated his previous opinion regarding the pneumoconiosis and causation issues; however, he modified his finding with respect to the total disability issue, as follows:

Conclusions

1. There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.

2. There is a disabling respiratory impairment present secondary to cigarette smoking.

3. From a respiratory standpoint, this man is disabled from returning to his last mining job or a job requiring similar effort.

4. Even if I were to assume that this man has coal workers' pneumoconiosis, conclusions #2 and #3 would remain the same.

(CX 21).

Dr. Fino issued another supplemental report, dated December 14, 2003 (EX 24), in which he stated that he had reviewed the following additional medical data: Dr. Bellotte's deposition transcript, dated November 3, 2003; Dr. Gaziano's report, dated November 14, 2003; Dr. Rasmussen's report, dated November 18, 2003; and, Dr. Rasmussen's deposition transcript, dated November 29, 2003. Following his discussion of the foregoing evidence, including the medical literature cited by Dr. Rasmussen, Dr. Fino concluded:

> The bottom line is very simple. It is my opinion that the inhalation of coal mine dust may cause an obstructive abnormality and may cause a disabling obstructive abnormality. Let us review this case again. Mr. Given stopped working in 1985. He had normal FVC and FEV1 values in 1986 and 1987. His lung function abnormality began five years after he left the mines. The studies cited by Dr. Rasmussen do not account for this man's reduction in FEV1 within the last 15 years. The studies support the hypothesis that the progression in this man's obstructive lung disease was secondary to cigarette smoking.
>
> Therefore, the additional information provided by Dr. Rasmussen and Dr. Gaziano does not cause me to change any of my previously stated opinions.

(EX 24).

Dr. Joseph J. Renn, III, a B-reader who is Board-certified in Internal Medicine, Pulmonary Disease, and Forensic Medicine, testified at deposition on January 10, 2002 (EX 8, pp. 3-6). Dr. Renn discussed his own x-ray interpretations of films dated December 31, 1998 and March 22, 2001; Mr. Given's coal mine employment ending in 1985; Dr. Renn's own evaluation in 1991; the medical records of Claimant's bypass surgery in 1994; Claimant's extensive smoking history; myocardial infarction; coronary artery disease; and, various clinical test results (EX 8, pp. 6-18). Based upon the foregoing, Dr. Renn opined that Claimant retains the ventilatory function to perform his coal mine employment; and, that Claimant's mild, reversible, obstructive impairment is related to emphysema and an asthmatic component. In addition, Claimant's arteriosclerotic heart disease is a factor in Claimant's shortness of breath. Furthermore, Dr. Renn stated that the Claimant does not suffer from a chronic coal mine dust-induced lung disease (EX 8, pp. 18-21).

In a supplemental report, dated June 28, 2002 (EX 10), Dr. Renn reviewed Dr. Sembello's letter, dated December 19, 2001, which he found to be similar to a previous letter by Dr. Sembello, dated July 14, 1998. In summary, Dr. Renn stated, in pertinent part:

> Dr. Sembello…bases his diagnosis of coalworkers' (sic) pneumoconiosis on radiographic evidence of "fibrosis," markedly impaired pulmonary function and impairment of "gas diffusion capacity." He stated, "Although Mr. Given does also have a degree of chronic obstructive lung disease, there is no denying that a fibrotic process has also contributed to his decrease in lung capacity."

> By his statements it is obvious that Dr. Sambello is not conversant with either coalworkers' (sic) pneumoconiosis as an obstructive ventilatory impairment, nor is he conversant with "fibrosis" being consistent with many pulmonary parencymal diseases, especially pulmonary respiratory bronchiolitis of a tobacco smoker. He is also not conversant with the various ventilatory function methods…[as]…evidence by his statement that Mr. Given has a decrease in lung capacity. Ventilatory function studies performed in this laboratory on March 18, 1991, reveal that he then had elevation of his forced vital capacity and also a mild elevation of his total lung capacity. Ventilatory function studies performed April 8, 1998 and March 22, 2001, also reveal normal forced vital capacities and the latter study also reveals a normal total lung capacity. The diffusing capacity is diminished but that is consistent with his tobacco smoke-induced pulmonary emphysema.
>
> In support of his contention that Mr. Given has coalworkers' (sic) pneumoconiosis Dr. Sembello has not offered any independently determined objective data.
>
> I find Dr. Sembello's letter of December 19, 2001, to be without scientific credibility and recommend that it be accorded little, if any, weight.

(EX 10).

Dr. Donald L. Rasmussen, who is Board-certified in Internal Medicine (CX 4), examined Claimant on April 30, 2003 (CX 1).[10] In a report on that date, Dr. Rasmussen set forth Claimant's past medical history, a smoking history of "½ pack of cigarettes a day at most until he quit in 1986," which had begun in 1944; and, a coal mine employment history of about 38 years ending in 1985. Dr. Rasmussen stated that Claimant's last job, as maintenance foreman, entailed carrying tools and lifting parts, such as wheels, pumps and motors. Accordingly, Dr. Rasmussen described the job as one in which Claimant "did considerable heavy manual labor." In addition, Dr. Rasmussen noted abnormal physical findings on examination and the positive (1/1) x-ray reading by Dr. Patel. Furthermore, Dr. Rasmussen reported Claimant's electrocardiogram as "within normal limits;" pulmonary function results indicative of a "moderate, slightly reversible obstructive ventilatory impairment;" and, "normal" resting blood gases. However, Dr. Rasmussen reported "marked impairment" with exercise. In summary, Dr. Rasmussen stated:

> These studies indicate at least marked loss of lung function. The patient does not retain the pulmonary capacity to perform his last regular coal mine job.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has coalworkers' (sic) pneumoconiosis which arose from his coal mine employment.

[10] Dr. Rasmussen had previously examined Claimant on June 9, 1986. On that occasion, Dr. Rasmussen reported a "moderate impairment" without directly addressing the total disability or pneumoconiosis issues (DX 35-12). As previously noted, Dr. Rasmussen had listed a smoking history of "½ – ¾ pack of cigarettes daily for 50 years," as well as a 39-year coal mine employment which ended in April 1985 (DX 35-12).

> The two causes of this patient's disabling lung disease are his previous cigarette smoking and his coal mine dust exposure. Both cause lung damage similar to some of Mr. Given's lung damage. His coal mine dust exposure, however, is likely to cause a greater impairment in oxygen transfer than ventilatory impairment as in this case. The patient's coal mine dust exposure is a major contributing factor to Mr. Given's disabling lung disease.

(CX 1).

Dr. Rasmussen testified at a deposition held on October 29, 2003 (CX 7). He reiterated the findings stated in the April 30, 2003 report: namely, that Claimant is totally disabled from performing coal mine employment due to his respiratory condition; the two causes of his respiratory condition are his histories of cigarette smoking and coal mine dust exposure; and, that he felt Claimant has coal worker's pneumoconiosis based on his work history and Dr. Patel's x-ray finding (CX 7, pp. 10-11). At deposition, Dr. Rasmussen also specified that the anatomical diagnoses were a "combination of emphysema and interstitial fibrosis, which were caused by coal mine dust exposure (CX 7, p. 11). Although Dr. Rasmussen stated that he has examined over 40,000 coal miners over the years, he acknowledged that he last actively treated patients in a hospital in 1964 and that he primarily conducts examinations for the purpose of doing pulmonary evaluations rather than seeing the coal miners as patients in a hospital or office setting (CX 7, pp. 34-36). Following a further discussion of medical literature, including some which he had authored, Claimant's history, and clinical test results, Dr. Rasmussen stated that, as of the April 30, 2003 evaluation, Claimant was totally disabled by his pulmonary condition; however, based on the 1986 clinical results, Claimant was not totally disabled at that time (CX 7, p. 49). While acknowledging that the reduced clinical results obtained on April 30, 2003 may have, in part, been due to the residual effects of Claimant's pneumonia, Dr. Rasmussen stated that it was not entirely due to pneumonia, because Claimant already had a moderate impairment in 1986 (CX 7, pp. 49-50). In addition, Dr. Rasmussen stated that a person who already has a significant respiratory impairment is more likely to get pneumonia (CX 7, p. 56). At the conclusion of his testimony, Dr. Rasmussen reiterated that, after his review of the 1986 evaluation and the questions posed at deposition, that coal mine dust exposure is a major contributing factor in Claimant's disabling lung disease (CX 7, pp. 62-63).

In a supplemental report, dated November 18, 2003 (CX 10), Dr. Rasmussen stated that he reviewed reports by Drs. Fino and Bellotte, dated October 28, 2003 and October 29, 2003, respectively. Dr. Rasmussen noted that, while Drs. Fino and Bellotte opined that Claimant suffers from a disabling lung disease, they found that it was not related to coal mine dust exposure. Dr. Rasmussen questioned the basis for Dr. Fino's opinion which had specified that the decline in FEV1 from ex-smokers was much more significant than those who were ex-coal miners. In so stating, Dr. Rasmussen also noted that "Dr. Fino felt that cigarette smoking was the cause of Mr. Given's loss of function even though Mr. Given had ceased cigarette smoking in about 1986." In addition, Dr. Rasmussen cited various medical articles, including some which he had authored, to support his opinion that Claimant's total disability is "the consequence of his cigarette smoking, but more significantly the consequence of his coal mine dust exposure." (CX 10).

Dr. William J. Sembello, Jr. issued a "To Whom It May Concern" letter, dated October 17, 2003 (CX 5), which is cursory and disjointed. The full text of the letter is as follows:

> I have cared for Mr. James Given for several years and (sic) my opinion his chest X-rays have shown pulmonary fibrosis. He has suffered considerable symptom etiology of shortness of breath, this and the duration of his coal mining work in addition to the findings (sic).
>
> On physical examination consistent with pulmonary fibrosis and increased pulmonary blood pressure certainly are consistent with the diagnosis of coal workers pneumoconiosis and have caused him considerable disability (sic).

(CX 5).[11]

Dr. Dominic Gaziano, a B-reader who is Board-certified in Internal, Pulmonary, and Critical Care Medicine, issued a report, dated November 14, 2003 (CX 6). Dr. Gaziano reviewed evidence, particularly the evaluations by Drs. Fino and Bellotte. In addition, Dr. Gaziano cited Dr. Bellotte's 0/1 interpretation of a March 22, 2001 film; his own interpretations of films from 1980 through October 9, 2003, which indicated a progression of disease to 1/2. In addition, Dr. Gaziano cited the progression from 0/1 to 1/0 as reported by Dr. Morgan. Furthermore, Dr. Gaziano stated that Dr. Morgan's 1/0 reading is "a definitive positive reading for occupational pneumoconiosis, particularly that due to coal mining." Accordingly, Dr. Gaziano could "not understand his [Dr. Morgan's] subsequent disclaimer that somehow this was not coal workers' pneumoconiosis." Dr. Gaziano added: "In any event, Dr. Morgan is an authority of international renown and this reading should carry some weight in the determination." In summary, Dr. Gaziano concluded:

> I believe that the evidence of Mr. Given having worked 38 years in the mines and having smoked anywhere from 30-50 pack years of history is conclusive evidence of chronic obstructive pulmonary disease and coal workers' pneumoconiosis.

(CX 6).

Discussion and Applicable Law

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. As stated above, the preponderance of the recent x-ray evidence, including the interpretations by

[11] Dr. Sembello had previously issued a letter, dated July 14, 1998, in which he had also found that there was "adequate evidence of disability from his coal workers' pneumoconiosis." Although the letter was less disjointed, it also was quite cursory (DX 37-20). Furthermore, the July 14, 1998 letter was apparently considered by the District Director's office. Nevertheless, the prior claim was finally denied on July 28, 1998 (DX 37-25).

B-readers and/or Board-certified radiologists, is negative for pneumoconiosis. Accordingly, the presence of pneumoconiosis has not been established pursuant to §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.201(a)(1) and (2).

As outlined above, the case file includes the recent medical opinions of Drs. Scattaregia (DX 13,34), Bellotte (DX 34; EX 9,13,21,22), Morgan (EX 1,11,18,25), Fino (EX 4,12,21,24), Renn (EX 8,10), Rasmussen (CX 1,7), Sembello (CX 5), and Gaziano (CX 6). Although Dr. Sembello has been treating Claimant for several years, I find that his analysis is cursory and neither well-reasoned nor well-documented. Therefore, I accord it no weight. Accordingly, the crux of this case rests on the relative weight to be given the medical opinions of Drs. Scattaregia, Bellotte, Morgan, Fino, and Renn, who found that Claimant does not suffer from coal worker's pneumoconiosis or any other chronic coal mine dust-induced disease versus those of Drs. Rasmussen and Gaziano, who diagnosed coal worker's pneumoconiosis and/or attributed a significant part of Claimant's respiratory impairment to his coal mine dust exposure.

Notwithstanding Claimant's coal mine employment history of 37 ¾ years, which ended in 1985, and a few positive interpretations for pneumoconiosis under the classification requirements of §718.102(b), I accord greater weight to the opinions of the former group of physicians than those of Drs. Rasmussen and Gaziano. In making this determination, I find that Dr. Rasmussen and Dr. Gaziano, in particular, placed undue emphasis on the few positive x-ray interpretations, in conjunction with Claimant's coal mine employment history. However, as stated above, the preponderance of the x-ray evidence is negative for pneumoconiosis. Moreover, the credible evidence establishes that Claimant's pulmonary impairment, if any, was clearly not disabling when he left the coal mines. Although pneumoconiosis is a progressive and latent disease, Drs. Scattaregia, Bellotte, Morgan, Fino, and Renn provided well-reasoned analyses of the clinical test results, in which they explained why Claimant's respiratory problems were not coal mine-related, but rather due to various other etiologies, such as his cardiac problems, asthmatic condition, and/or Claimant's extensive cigarette smoking history. Furthermore, I find that the reports and/or deposition testimony of Drs. Scattaregia, Bellotte, Morgan, Fino, and Renn are more thorough than those of Dr. Rasmussen and, in particular, that

of Dr. Gaziano. Moreover, among the Board-certified pulmonary specialists, Drs. Bellotte, Morgan, Fino, and Renn found the evidence is insufficient to establish coal worker's pneumoconiosis and/or that Claimant does not suffer from any significant coal mine related impairment. By contrast, only Dr. Gaziano diagnosed the disease.

In view of the foregoing, I accord greater weight to the opinions of Drs. Bellotte, Morgan, Fino, and Renn, as buttressed by Dr. Scattaregia, over the opinions of Drs. Sembello, Gaziano, and Rasmussen regarding the pneumoconiosis and causation issues. Accordingly, I find that Claimant has failed to establish the presence of pneumoconiosis under §718.202(a)(4), or by any other means.

Pursuant to the Fourth Circuit's holding in *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000), I have weighed all of the evidence together under 20 C.F.R. §718.202(a). As outlined above, the record contains some positive x-ray interpretations and physician opinions which diagnosed simple pneumoconiosis. However, as set forth herein, I find that the preponderance of the x-ray evidence is negative for pneumoconiosis and that the preponderance of the credible medical opinion evidence does not establish (clinical or legal) pneumoconiosis. Therefore, I find that Claimant has not established pneumoconiosis under §718.202(a).

Causal Relationship

Since Claimant has failed to establish the presence of pneumoconiosis, he also has failed to establish that the disease arose from coal mine employment. If Claimant had established the existence of simple pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203.

Total Disability Due to Pneumoconiosis

As outlined above, the majority of the recent pulmonary function studies are qualifying. Furthermore, several of the recent physicians' opinions, including those offered by Employer, state that Claimant's current pulmonary problems would preclude him from performing his last usual coal mine job. Therefore, even though the recent arterial blood gas studies are inconclusive, I find that Claimant has established that he suffers from a total (pulmonary or respiratory) disability. 20 C.F.R. §718.204(b). However, as previously noted, the denial of the most recent claim was not based on the "total disability" issue, but rather the elements of pneumoconiosis, causal relationship, and causation. Accordingly, my finding of total disability does not represent a material change in conditions under 20 C.F.R. §725.309.

For the reasons discussed above, I find that Claimant has not established (clinical or legal) pneumoconiosis by a preponderance of the evidence. Therefore, he has also failed to establish total disability due to pneumoconiosis, as defined in §718.204(c).

Conclusion

Having considered the relevant evidence, I find that Claimant has established about 37 ¾ years of coal mine employment, which ended in 1985 and that he suffers from a totally disabling pulmonary or respiratory impairment. However, Claimant has not established the presence of pneumoconiosis by a preponderance of the evidence. Furthermore, Claimant has also failed to establish that his total disability is due to pneumoconiosis. Therefore, Claimant is not eligible for benefits under the Act and regulations.

Finally, assuming *arguendo* that my "total disability" finding constituted a material change in condition under §725.309, it would not effect the outcome herein. In making this determination, I note that the early x-ray evidence was, at best, inconclusive. Furthermore, as set forth above, many of the recent opinions were rendered by physicians who had issued prior reports. Moreover, in view of the progressive nature of pneumoconiosis, the more recent evidence is generally deemed more probative. Therefore, even when one considers the medical evidence presented in the three prior claims (DX 35, 36, 37), in conjunction with the evidence submitted in the current claim, it still does not establish the presence of pneumoconiosis and/or disability causation.

Attorney's Fees

The award of an attorney fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of James O. Given for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.